Please fax all pages of completed form to your team at 808.650.6487.

To reach your team, call toll-free 808.650.6488.

You can now monitor shipments and chat online if you have questions. Go to MyAccredoPatients.com to log in or get started.

Prescription & Enrollment Form

Sickle Cell Disease (SCD)

accredo®
677 Ala Moana Blvd., Suite 404,
Honolulu, HI 96813-5412

Four simple steps to submit your referral.

1 Patient Information

Please provide copies of front and back of all medical and prescription insurance cards.

☐ New patient ☐ Current patient

Patient's first name _____ Last name _____ Middle initial _____

Preferred patient first name _____ Preferred patient last name _____

Sex at birth: ☐ Male ☐ Female Gender identity _____ Pronouns _____ Last 4 digits of SSN _____

Date of birth _____ Street address _____ Apt # _____

City _____ State _____ Zip _____

Home phone _____ Cell phone _____ Email address _____

Parent/guardian (if applicable) _____

Home phone _____ Cell phone _____ Email address _____

Alternate caregiver/contact _____

Home phone _____ Cell phone _____ Email address _____

☐ OK to leave message with alternate caregiver/contact

Patient's primary language: ☐ English ☐ Other If other, please specify _____

Provider will read the following statement: By providing the phone number(s) and email address above, you consent to receiving automated/artificial voice calls, emails and/or text messages from Accredo about your prescription(s), account, and health care. Standard data rates apply. Message frequency varies.

2 Prescriber Information

All fields must be completed to expedite prescription fulfillment.

Date _____ Time _____ Date medication needed _____

Office/clinic/institution name _____

Prescriber's first name _____ Last name _____

Prescriber's title _____ If NP or PA, under direction of Dr. _____

Office phone _____ Fax _____ NPI # _____ License # _____

Office contact and title _____ Office contact email _____

Office street address _____ Suite # _____

City _____ State _____ Zip _____

Deliver product to: ☐ Prescriber's office ☐ Patient's home

3 Clinical Information

Sickle Cell Diagnosis **(REQUIRED)**: ☐ D57 (sickle cell disorders) ☐ D57.0 (Hb-SS disease with crisis) ☐ D57.1 (SCD without crisis)
☐ D57.2 (Sickle-cell/Hb-C disease) ☐ D57.00 (Hb-SS disease with crisis, unspecified)
☐ D57.40 (Sickle-cell thalassemia without crisis) ☐ D57.20 (Sickle-cell/Hb-C disease without crisis)
☐ D57.219 (Sickle-cell/Hb-C disease with crisis, unspecified) ☐ Other _____

Date recorded _____ Height _____ cm/in Weight _____ kg/lbs Date taken _____

☐ NKDA ☐ Known drug allergies _____

Concurrent meds _____

Additional clinical information _____

Patient's first name _____ Last name _____ Middle initial _____ Date of birth _____

Prescriber's first name _____ Last name _____ Phone _____

4 Prescribing Information

<table>
<tr><th>Medication</th><th>Dose</th><th>Directions</th><th>Quantity/Refills</th></tr>
<tr>
<td>☐ l-glutamine</td>
<td>5 Gram (GM) Packet</td>
<td>
<table>
<tr><th>Weight in kilograms</th><th>Per dose in grams</th><th>Per day in grams</th><th>Packets per dose</th><th>Packets per day</th></tr>
<tr><td>less than 30</td><td>5</td><td>10</td><td>1</td><td>2</td></tr>
<tr><td>30 to 65</td><td>10</td><td>20</td><td>2</td><td>4</td></tr>
<tr><td>greater than 65</td><td>15</td><td>30</td><td>3</td><td>6</td></tr>
</table>
☐ Mix 1 packet (5 GM) with 8 ounces (240mL) of cold or room temperature liquid or 4–6 ounces of food and take by mouth 2 times daily.
☐ Mix 2 packet(s) (10 GM) with 8 ounces (240mL) of cold or room temperature liquid or 4–6 ounces of food and take by mouth 2 times daily.
☐ Mix 3 packet(s) (15 GM) with 8 ounces (240mL) of cold or room temperature liquid or 4–6 ounces of food and take by mouth 2 times daily.

☐ Other _____
</td>
<td>☐ 1-month supply
☐ 3-month supply
☐ Other
_____
Number refills authorized _____</td>
</tr>
<tr><td>☐ Other</td><td></td><td></td><td></td></tr>
</table>

You must note the name of the brand product if brand is medically necessary for your patient _____

Prescriber's signature required (sign below) (Prescriber attests this is his/her legal signature. NO STAMPS)

SIGN HERE

_____ **Date** _____ **Dispense as written** _____ **Date** _____ **Substitution allowed**

The prescriber is to comply with his/her state-specific prescription requirements such as e-prescribing, state-specific prescription form, fax language, etc. Non-compliance with state-specific requirements could result in outreach to the prescriber.

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